

Arkansas State Board of Nursing

University Tower Building
1123 South University Avenue, Suite 800
Little Rock, Arkansas 72204

PHONE 501.686.2700

FAX 501.686.2714

www.arsbn.org

INSTRUCTIONS FOR COMPLETION OF ADVANCED PRACTICE NURSE LICENSURE APPLICATION

I. QUALIFICATIONS

- A. Current unencumbered Arkansas RN license or current RN license from a compact state which is your primary state of residence. *Primary state of residence* means the state of a person's declared fixed permanent and principal home for legal purposes; domicile. The following items could be requested as proof of primary state of residence: driver's license, voter registration card, and federal income tax return. To determine compact states, see www.arsbn.org and click on Nurse Licensure Compact.
- B. Effective January 1, 2003, all applicants for licensure by examination shall have completed a graduate level advanced practice nursing education program. Applicants for licensure by endorsement shall provide documentation that they have completed a graduate level nursing education program or held national certification and were licensed in an other jurisdiction as an advanced practice nurse prior to January 1, 2003.
 1. Advanced Nurse Practitioner (ANP)
 - a. Successful completion of an organized program of nursing education that prepares nurses for the advanced practice role of advanced nurse practitioner; and
 - b. Current certification as a nurse practitioner by a nationally recognized certifying body approved by the Board of Nursing.
 2. Certified Registered Nurse Anesthetist (CRNA)
 - a. Satisfactory completion, beyond generic nursing preparation, of a formal education program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs or another nationally recognized accrediting body that has as its objective preparation of nurses to perform as nurse anesthetists; and
 - b. Current certification from the Council on Certification on Nurse Anesthetists, Council of Recertification of Nurse Anesthetists, or another nationally recognized certifying body approved by the Board of Nursing.
 3. Certified Nurse Midwife (CNM)
 - a. Successful completion of an organized program of nursing education that prepares nurses for the advanced practice role of nurse midwife;
 - b. Current certification as a nurse midwife from the American College of Nurse Midwives, or other nationally recognized certifying body approved by the Board of Nursing; and
 - c. Agreement with a consulting physician, if involved in intrapartum care.
 4. Clinical Nurse Specialist (CNS)
 - a. Master's degree evidencing successful completion of a graduate program in nursing, which shall include supervised clinical practice and classroom instruction in a nursing clinical practice specialty; and
 - b. Current certification in a specialty role as a clinical nurse specialist from a national recognized certifying body approved by the Board of Nursing.

II. REQUIREMENTS

- A. APN Licensure
 1. One hundred dollars (\$100) and **completed** application form. **FEES ARE NON-REFUNDABLE.**
 2. A current Arkansas RN license or a current RN license from a compact state which is your primary state of residence. If you are seeking licensure as an advanced practice nurse in Arkansas and reside in a compact state other than Arkansas, you must verify the compact RN license to us. Submit your verification request online to www.nursys.com (fee required). A temporary RN permit does not meet this requirement.
 3. A transcript sent directly from your advanced practice program to the Board of Nursing.
 4. Documentation of current certification in good standing sent directly from the certifying body.
 5. CNMs only: If involved in intrapartum care, submit an agreement with a consulting physician.
 6. Arkansas law requires all applicants for advanced practice licensure to submit to a criminal background check and FBI fingerprint check. (The FBI fingerprint card must be obtained from the ASBN office.) If an applicant has pleaded guilty or nolo contendere to any offense listed in ACA § 17-87-312 he or she is not eligible for Arkansas licensure. (*ACA § 17-87-312 provides opportunity to request a waiver of eligibility criteria related to a criminal background in certain circumstances.) The criminal background check shall be completed no earlier than twelve (12) months prior to the application for licensure. If the criminal background check is older than twelve (12) months, it must be repeated.
 7. Endorsement applicants only: Complete and mail the document entitled Advanced Practice Verification Form to the state of your current advanced practice licensure. The licensing agency will complete the form and return it directly to this office. Most states charge a fee for this service (contact the state).
 8. Endorsement applicants only - Prescriptive Authority is not automatically granted with an advanced practice license in Arkansas. There is a separate application process. See "Forms" on the Web site.

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- B. Temporary Permits (Temporary permits are not renewable and do not apply to Prescriptive Authority.)
1. Exam Temporary Permit
 - a. Transcript sent directly from the advanced practice nursing education program.
 - b. Copy of your acceptance to sit for the **first available** required national certifying examination or verification of acceptance to sit for the exam sent directly from the certifying body.
(Permit expires upon notification of exam results and shall not be valid in excess of six months.)
 2. Endorsement Temporary Permit
 - a. Copy of current ASBN approved certification in the appropriate advanced practice nursing education category.
 - b. Copy of current APN licensure or its equivalent from another jurisdiction.
(Permit shall not be valid in excess of six months.)
 3. All Temporary Permits
 - a. Appropriate fee (\$25 plus licensure fee) and completed application form.
 - b. A current Arkansas RN license or a copy of a current RN license from a compact state which is your primary state of residence.
 - c. Arkansas criminal background check. (See item A.6. above.)

III. CERTIFICATION: The following credentialing bodies' examinations are approved by the Board of Nursing.

American Association of Critical Care Nurses (www.aacn.org)

Acute/CriticalCare Clinical Nurse Specialist - Adult
Acute/Critical Care Clinical Nurse Specialist - Neonatal
Acute Care Nurse Practitioner

American Midwifery Certification Board (www.accmidwife.org)

Certified Nurse Midwife

American Nurses Credentialing Center (<http://www.nursecredentialing.org>)

Acute Care Nurse Practitioner
Adult Nurse Practitioner
Adult Psychiatric and Mental Health Nurse Practitioner
Clinical Nurse Specialist in Adult Health Nursing
Clinical Specialist in Adult Psychiatric and Mental Health Nursing
Clinical Specialist in Child and Adolescent Psychiatric and Mental Health Nursing
Clinical Specialist in Gerontological Nursing
Clinical Specialist in Pediatric Nursing
Family Nurse Practitioner
Family Psychiatric and Mental Health Nurse Practitioner
Gerontological Nurse Practitioner
Pediatric Nurse Practitioner

National Certification Corporation (www.nccnet.org)

Neonatal Care Nurse Practitioner
Women's Health Care Nurse Practitioner

National Board on Certification and Recertification of Nurse Anesthetists (<http://www.nbcna.com>)

Certified Nurse Anesthetist

American Academy of Nurse Practitioners (www.aanp.org)

Adult Nurse Practitioner
Family Nurse Practitioner

Pediatric Nursing Certification Board (www.pncb.org/ptistore/control/index)

Pediatric Nurse Practitioner (primary care)
Pediatric Nurse Practitioner (acute care)

FALSIFICATION OF THIS FORM IS GROUNDS FOR DISCIPLINARY ACTION AGAINST YOUR LICENSE

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UNIVERSITY TOWER BUILDING

1123 SOUTH UNIVERSITY, SUITE 800

LITTLE ROCK, ARKANSAS 72204

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ADVANCED PRACTICE NURSE LICENSE APPLICATIONFull Name _____
(MISS, MS, MRS, OR MR) FIRST MIDDLE MAIDEN LASTPhysical Address _____
STREET CITY STATE ZIPMailing Address _____
STREET/P.O.BOX CITY STATE ZIPDate of Birth _____ Place of Birth _____ Gender _____ Male _____ Female
MONTH DAY YEAR CITY STATE

Social Security Number _____ Telephone No. () _____ E-mail _____

Have you ever been convicted of a misdemeanor or felony, pled guilty or nolo contendere to any charge in any state or jurisdiction? DWI's and similar offenses must be reported. (Traffic violations do not constitute a crime.) YES ☐ NO ☐
(If yes, include a certified copy of the court docket, plea agreement or conviction papers, and evidence that fines, restitution are paid.)

Have you ever had any license, certificate, registration, or privilege to practice disciplined (revoked, suspended, placed on probation, or reprimanded) or voluntarily surrendered in any state or jurisdiction? YES ☐ NO ☐
(If yes, include copy of Facts and Finding from Board and evidence of reinstatement of license)

Are you currently under investigation in any state or jurisdiction? YES ☐ NO ☐Do you currently engage in drug-related behavior, including the use of mood-altering drugs/substances and/or alcohol that would affect your functional abilities to perform while working as a nurse? YES ☐ NO ☐

In the last two years, have you been the subject of a chemical or alcohol dependency intervention or participated in chemical or alcohol dependency treatment/rehabilitation? YES ☐ NO ☐
(If yes, submit all relevant documents, such as rehab program completion, support group meetings, drug screens, etc.)

ETHNIC INFORMATION (check one): ☐ African American ☐ Asian Indian ☐ Asian Other ☐ Hispanic
☐ Native American ☐ Pacific Islander ☐ White, not of Hispanic origin ☐ Other

LICENSURE/CERTIFICATION

Check the category of advanced nursing practice in which you seek licensure:

- ☐ Advanced nurse practitioner (ANP) ☐ Certified registered nurse anesthetist (CRNA)
☐ Certified nurse midwife (CNM) ☐ Clinical nurse specialist (CNS)

Arkansas RN license number _____ Pending? NO ☐ YES ☐ Expiration date ____/____/____

Primary state of residence (if not Arkansas) _____

RN license number _____ Expiration date ____/____/____

Do you hold advanced licensure/certification in this or any other state? YES ☐ NO ☐

If yes, specify the state(s), the category and specialty (if applicable) with licensure/certification number(s) and expiration date(s): _____

EDUCATION BACKGROUND**BASIC REGISTERED NURSE EDUCATION**

Name of Program _____

Year Graduated _____ State _____

FOR OFFICE USE ONLY

APN LICENSE # _____

DATE _____

CBC (S) _____

(F) _____

TP _____ DATE _____

ADVANCED PRACTICE NURSE EDUCATION

Name and Address of Advanced Practice Program _____

Program Length _____ Check Type: ☐ Certificate (No academic degree) ☐ Master's Degree

Area of Study or Specialization _____ ☐ CRNA ☐ CNM ☐ CNS ☐ ANP

Attended from _____ to _____ Year Graduated _____ Degree Awarded (if applicable) _____

ADDITIONAL (OTHER) EDUCATION

Name of Program/Institution _____

Year Graduated _____ Degree Awarded _____ Area of Study _____ Years Attended _____

SPECIALITY CERTIFICATION HELD OR APPLIED FOR

☐ CRNA (CCNA) ☐ CNM (ACC) ☐ CNS (ANCC) ☐ ANP Certifying Body _____

Exam Title _____ Certification Number _____ Expiration Date _____

CNM'S ONLY: If involved in intrapartum care, do you have an agreement with a consulting physician? YES ☐ NO ☐

TEMPORARY PERMIT (select one)

☐ **Exam Temporary Permit:** Name of examination _____ Certifying Body _____
Date of examination: Applied for _____ Taken _____

☐ **Endorsement Temporary Permit:**
State of original advanced practice licensure _____

Advanced Practice License Fee \$100.00
Temporary Permit \$ 25.00

METHOD OF PAYMENT

- ☐ In-state personal check
☐ Money order/cashiers check
☐ Credit card

FEES ARE NONREFUNDABLE

CREDIT CARD INFORMATION

Complete below if paying by credit card. There is a nominal processing fee (listed below) assessed with paying your fees by credit card. The Arkansas State Board of Nursing does not receive any portion of the processing fee.

Type of card Visa ☐ MasterCard ☐ Discover ☐

Cardholder's Name _____

Cardholder's billing address _____

City _____ State _____ Zip _____

Credit Card # _____

Expiration date ____/____/____ Amount Paid _____
mm yyyy

Signature _____

*Processing fee - Advanced practice application - \$3.00; Temporary Permit - \$0.75

AFFIDAVIT

State of _____

County of _____

I, _____, being duly sworn or affirmed, state that I am the person who is referred to in the foregoing application for licensure as an advanced practice nurse in the State of Arkansas; that the statements herein contained are true in every respect; that I agree to comply with all requirements of the law; and that I have read and understand this affidavit. I hereby give my consent for the Arkansas State Police and FBI to release the criminal background checks results to the Arkansas State Board of Nursing. I understand that (1) if the processing of this application is not completed, the application becomes null and void one year from date received; (2) falsification of this form is grounds for discipline against my license; and (3) all fees are non refundable.

Sworn to before me this _____ day of _____ 20____
My Commission Expires _____

NOTARY SEAL

APPLICANT'S SIGNATURE

NOTARY PUBLIC

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FBI and ARKANSAS CRIMINAL BACKGROUND CHECKS INSTRUCTIONS

Use these instructions if you are: an out-of-state graduate, rewrite applicant, internationally educated, advanced practice applicant or endorsing into Arkansas. **IF YOU ARE ENROLLED IN AN ARKANSAS NURSING EDUCATIONAL PROGRAM YOU MUST SUBMIT YOUR BACKGROUND CHECKS THROUGH YOUR NURSING PROGRAM. DO NOT FOLLOW THESE DIRECTIONS.**

Submit to the Board of Nursing, one cashier's check or money order for \$38.50 made payable to the Arkansas State Board of Nursing, along with the completed Arkansas State Police form and fingerprint card. **FEES ARE NONREFUNDABLE.**

Complete your applications in the following manner:

1. **ARKANSAS STATE POLICE CRIMINAL BACKGROUND CHECK FORM**
 - a. Complete the Arkansas State Police Criminal Background Check Form. Every question MUST be answered or the form will be returned to you.
 - b. The name on your Criminal Background Check Form **MUST** be your legal name.
 - c. You must have a social security number. If you do not have one, contact the Board of Nursing (501.686.2709) for further instructions. Do not leave this blank.
 - d. **THE ARKANSAS STATE POLICE CRIMINAL BACKGROUND CHECK FORM MUST BE NOTARIZED.**
2. **FBI FINGERPRINT CARD (You MUST use the card provided by ASBN)**
 - a. Complete the following boxes on the card (type or print, **black ink only**)
 - Last name, first name, middle name
 - Signature of person fingerprinted
 - Aliases (other names you have used, including nicknames, maiden name, other married names, etc.)
 - ORI (this block should read: AR920430Z State Board of Nursing, Little Rock, AR)
 - Date of birth (numeric month, numeric day, numeric year)
 - Residence of person fingerprinted (street address or post office box, city, state, zip)
 - Citizenship (i.e., United States, England, Philippines)
 - Sex, race, height, weight, eyes (color), hair (color)
Sex: M=Male; F=Female
Race: A=Asian; W=White; B=Black; I=American Indian; U=Unknown; (If Hispanic use "W")
Eyes: BLU=Blue; BRO=Brown; BLK=Black; GRY=Gray; GRN=Green; HAZ=Hazel; MAR=Maroon; PNK=Pink; XXX=Unknown
Hair: BAL=Bald; BRO=Brown; SDY=Sandy; BLK=Black; GRY=Gray; WHI=White; BLN=Blond; RED=Red; XXX=Unknown
 - Place of birth (city, state, or foreign country)
 - Employer and address ("none" if you are unemployed)
 - Reason fingerprinted - write in: AR State Board of Nursing - ACA §17-87-312
 - Social Security number
 - Leave all other spaces blank (OCA, FBI, MNU, MNU)
 - b. Have fingerprints done by properly trained personnel. Your local police or sheriff's department may be willing to accommodate you. There may be a fee involved. The Arkansas State Police ID Bureau in Little Rock on Geyer Springs Road at I-30 will collect your fingerprints without charge Monday - Friday, 8:00 a.m. - 4:30 p.m.

If an individual is missing one or more fingers, a notation in the fingerprint block(s) indicating why a partial or missing image exists must be written in. Handwritten notations recommended for fingerprint submissions include: Amp (amputated), Ti--Amp (tip amputated), Missing at Birth, Cut-off, Shot-off, Deformed and Missing.

Common errors that will delay the processing of your FBI criminal background check are incomplete FBI fingerprint card and poor quality of fingerprints. **DO NOT BEND OR FOLD THE FBI FINGERPRINT CARD.**
3. Submit to ASBN:
 - a. One cashier's check or money order, payable to ASBN, for \$38.50
 - b. Arkansas State Police Criminal Background Check Form (notarized)
 - c. FBI Fingerprint Card

DO NOT, UNDER ANY CIRCUMSTANCES, CONTACT THE ARKANSAS STATE POLICE OR THE FBI ABOUT THE STATUS OF YOUR CRIMINAL BACKGROUND CHECKS.

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ARKANSAS STATE POLICE CRIMINAL BACKGROUND CHECK FORM

Please type or print clearly.

NAME: LAST FIRST MIDDLE MAIDEN

OTHER NAMES YOU HAVE USED RACE SEX SOCIAL SECURITY NUMBER

EYE COLOR HAIR COLOR HEIGHT WEIGHT E-MAIL ADDRESS

DATE OF BIRTH PLACE OF BIRTH (STATE) DRIVER'S LICENSE # STATE OF ISSUE

MAILING ADDRESS CITY STATE/COUNTRY ZIP CODE

DAYTIME PHONE NUMBER

I, THE UNDERSIGNED, HEREBY GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE TO CONDUCT THE REQUIRED CRIMINAL RECORD CHECKS ON MYSELF AND RELEASE ANY RESULTS TO THE ARKANSAS STATE BOARD OF NURSING.

SIGNATURE OF APPLICANT

DATE

RETURN THIS FORM, FINGERPRINT CARD AND A CASHIER'S CHECK OR MONEY ORDER (no personal checks) FOR \$38.50 PAYABLE TO ASBN TO:

Arkansas State Board of Nursing, 1123 S. University Avenue, #800, Little Rock, AR 72204

Fees are nonrefundable

YOU MUST HAVE THIS FORM NOTARIZED.

State of _____

County of _____

Sworn to before me this _____ day of _____ 20 _____

My Commission Expires _____

NOTARY SEAL

SIGNATURE Notary Public

Arkansas State Board of Nursing

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ADVANCED PRACTICE VERIFICATION FORM

COMPLETE PART 1 AND FORWARD THIS FORM TO THE BOARD OF NURSING IN THE JURISDICTION WHERE YOU ARE CURRENTLY LICENSED AS AN ADVANCED PRACTICE NURSE AND/OR HAVE PRESCRIPTION PRIVILEGES.

PART 1:

Name (Last, First, Maiden/Middle):		
Street Address		
City	State	Zip Code
RN License Number	Advanced Practice License Number	Prescriptive Authority Number

PART 2:

THE ABOVE NAMED PERSON HAS APPLIED FOR A CERTIFICATE OF PRESCRIPTIVE AUTHORITY AND/OR AN ADVANCED PRACTICE LICENSE BY ENDORSEMENT. PLEASE COMPLETE AND RETURN TO:

Arkansas State Board of Nursing
University Tower Building
1123 South University Ave., Suite 800
Little Rock, AR 72204

I hereby verify that _____ (print name)
has met the initial criteria for advanced practice licensure and/or prescriptive authority.

Does the licensee currently hold an advanced practice license in your jurisdiction? Yes ☐ No ☐

Is the licensee currently authorized to prescribe in your jurisdiction? Yes ☐ No ☐

Is Prescriptive Authority automatically granted with APN licensure? Yes ☐ No ☐

Advanced Practice License Number _____ Date of Issuance _____

Prescriptive Authority License/Certificate Number _____ Date of Issuance _____

Has license/certificate ever been encumbered? Yes ☐ No ☐ If yes, please attach a certified copy of Board order.

Is applicant currently under investigation? Yes ☐ No ☐

Seal _____ Executive Director _____

State of _____

Dated at _____ this _____ day of _____ 20_____

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VERIFICATION OF NATIONAL CERTIFICATION

Part I: To be completed by the applicant and forwarded to the certifying body.

Name (Last, First, Maiden/Middle):	
Street Address:	
City:	State: Zip Code:
Social Security Number:	Date of Birth:
Certification Number:	Expiration Date:
Signature:	Date:



Part II: To be completed by the certifying body and forwarded directly to the Arkansas State Board of Nursing at the address shown above.

This is to certify that the person identified above has met the requirements for certification or decertification by the:		
Name of Certifying Agency		
Specialty Area of Certification		
Date of Certification	Certification Number	Expiration Date
Authorized Signature of Certifying Agency		Date
Print or Type Name and Title		Seal

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CHECKLIST FOR INITIAL LICENSURE

CRIMINAL BACKGROUND CHECK

1. Complete criminal background check (CBC) process a few months prior to graduation or as directed by your Advanced Practice Nursing program. Follow the directions on the CBC instructions.
 - Go to www.arsbn.org, select the Adv. Practice tab, select link to download the Advanced Practice Licensure Application Instructions. The CBC form and instructions are included. If you need another CBC form &/or fingerprint card:
 - Select "Yes" if you need a fingerprint card and CBC form/instructions
 - Select "No" if you only need the CBC form/instructions

*If you have ever been convicted of a misdemeanor or felony, pled guilty or nolo contendere to any charge in any state or jurisdiction (even if your conviction was sealed or expunged), select "Yes" and include a certified copy of the court docket, plea agreement or conviction papers, and evidence that all fines/restitution have been paid. DWIs and similar offenses must be reported (minor traffic violations do not constitute a crime).

OFFICIAL TRANSCRIPT

2. Upon completion of your respective program of study, have your Advanced Practice Nursing program send an official transcript to the Arkansas State Board of Nursing (ASBN), attention to Ellen Harwell.

APPLICATION & FEE

3. Submit completed application for APN license, including \$100 fee (additional \$25 if Temporary Permit desired) to the ASBN.

CERTIFICATION EXAM

4. Have certifying body submit proof that you passed the certification exam (for Temporary Permit, submit proof that you are eligible to sit for the certifying exam at the next available date.)

PRESCRIPTIVE AUTHORITY

5. After licensure as an APN, you may apply for Prescriptive Authority with \$150.00 fee.
 - You do not automatically receive Prescriptive Authority with the issuance of your APN license. The application process for Prescriptive Authority must be followed.
 - You are required to submit your Collaborative Practice Agreement and Quality Assurance (QA) Plan with your Prescriptive Authority application and fee. Both of these documents must be signed by the APN and the collaborating physician. You are welcome to use the examples provided on our website (under the Adv. Practice tab) – feel free to make changes to accommodate the agreement between you and your collaborating physician. However, there is required criteria that must be included in the Collaborative Practice Agreement and Quality Assurance Plan.

DEA NUMBER REGISTRATION

6. After receiving Prescriptive Authority, if you plan to prescribe Schedules III – V controlled substances, apply for a DEA #. Directions for applying for a DEA # are provided on our website (under the Adv. Practice tab). Submit a copy of your DEA # card to the ASBN after you receive it.

Please refer to our website for additional information: www.arsbn.org